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ABSTRACT

Intended for teachers of young children exposed to violence in their communities, this paper presents an introduction to post-traumatic stress disorder (PTSD), including its definition, symptoms, causes, and providing a supportive classroom environment. The definition discussed is based on that of the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders, as are the listed criteria for diagnosing PTSD. Other aspects of PTSD discussed include re-experiencing the traumatic event, avoiding reminders of traumatic events, symptoms of increased arousal, and clinically significant distress. A section on working with children diagnosed with PTSD notes additional symptoms a teacher might see in the classroom, such as hyper and hypovigilance and increased sensitivity to sound and touch. Classroom guidelines address helping the child learn to feel safe in the classroom, activities that promote safety, responding to developmental delays caused by PTSD, the role of the classroom staff with the child and family, behavioral issues, individualizing behavior management, setting limits in the classroom, making a referral, and working with the family and professionals. (Contains 17 references.) (DB)

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RESPONDING TO VIOLENCE IN THEIR LIVES: CREATING NURTURING ENVIRONMENTS FOR CHILDREN WITH POST-TRAUMATIC STRESS DISORDER

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INTRODUCTION

Many children in Head Start classrooms live in increasingly violent communities. This chaos poses an ongoing threat to children's physical safety, and the entire community is constantly "on guard" against crime and violence.

Children may also experience violence inside the home: the number of children in the U.S. who are physically and sexually abused is significant. "In 1991, state child protective services agencies received and referred for investigation an estimated 1.8 million reports of alleged child abuse and neglect, involving approximately 2.7 million children" (NCANDS, 1993).

Families and children living with violence are at risk for developing Post-Traumatic Stress Disorder (PTSD) — a condition which often goes undiagnosed or misdiagnosed. (Head Start staff living in unsafe communities are also at risk.) This resource file describes the symptoms and causes of PTSD in children. It was developed to guide classroom staff and others in identifying the symptoms; working with the child, family, and other professionals; and looking at the overall impact of PTSD on communities.

Research documents the conditions that may result in a child being diagnosed with PTSD (Famularo, Fenton, & Kinsscherff 1993; Garbarino, Kostelny, & Dubrow 1991; Terr 1990). PTSD is a relatively new diagnosis for children and the symptoms may be misleading or difficult to observe. While only psychiatrists or psychologists are qualified to diagnose children with PTSD, teachers' careful observations of children's behavior will assist qualified professionals in making the diagnosis.

Working with the families of children diagnosed with PTSD can be difficult, especially when there is a history of abuse. When a child's witnessing violence leads to PTSD, often the family members are suffering from trauma as well. Working with the children's families requires great care and sensitivity toward these issues.

Given these risk factors, all teachers should be aware of the symptoms of PTSD, how it comes about, and how to create a classroom environment that supports children with PTSD and their families.

DEFINITION OF POST-TRAUMATIC STRESS DISORDER

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-4) defines the conditions that would warrant a diagnosis of a psychological disorder by a psychiatrist, psychologist or other mental health professional.

Post-Traumatic Stress Disorder is the "development of symptoms following exposure to an extreme traumatic event or involving direct personal experience to an event that involves threatened death, actual or threatened serious injury, or

other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror." (DSM-4, 1994)

Some examples of traumatic events include violent personal attack, kidnapping, torture, natural or man-made disasters, and severe automobile accidents. "For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury." (DSM-4, 1994)

Witnessed events may include "observing serious injury or unnatural death of another person due to a violent assault. The disorder may be especially severe or long lasting when the event is of human design, for example, sexual abuse, kidnapping or torture." (DMS-4, 1994)

SYMPTOMS PRESENT IN CHILDREN WITH PTSD

The DSM-4 specifies the following criteria for diagnosing children with PTSD. Examples describing how children might display these symptoms follow each list of criteria.

Exposure to a Traumatic Event

"The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or other.

2. The person's response involved intense fear, helplessness, or horror. NOTE: In children this may be expressed instead by disorganized or agitated behavior." (DSM-4, 1994)

For example, Terry was repeatedly sexually abused by her father. Her response during the abuse was one of helplessness. Her teacher, Mim, reported that during this period Terry seemed unusually agitated and fearful of almost everything. In addition Terry was unable to concentrate or organize her playtime in any way. Mim noted this as different behavior for Terry, who had, in the past, been one of the children in the classroom who had quickly organized her time.

Re-experiencing the Traumatic Event

"The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. NOTE: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. NOTE: In children, there may be frightening dreams without recognizable content.

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). NOTE: In young children, trauma-specific reenactment may occur.

4. Intense psychological reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event." (DSM-4, 1994)

Here are some examples of the symptoms described above. Elizabeth, who spends most of her time in the housekeeping area hiding the dolls under blankets and saying, "Shhh! I hear him coming," may be engaged in repetitive play. Amy, who has nightmares about a "big, huge monster coming after me," may be experiencing recurrent distressing dreams of the trauma even though the dream's content doesn't directly correspond. Repetitive play can indicate trauma-specific reenactment of a traumatic event. For example, Peter, who witnessed a hurricane, plays a game with broccoli, saying, "Hurricane Hugo is coming," as the broccoli "blows over" (Saylor, Swenson, Cupit & Powell, 1992). Sarah, who witnessed a shooting may run for cover any time a loud bang is heard. This is a physiological reaction to an external cue that symbolizes an

aspect of the traumatic event. Similarly, Joshua, who is terrified of men with mustaches, shows intense psychological distress at exposure to an external cue.

Remember, the teacher's role is not to diagnose any child, but to carefully observe behavior to gather helpful information.

Avoiding Reminders of Traumatic Events

"Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), are present as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3. Inability to recall an important aspect of the trauma.

4. Markedly diminished interest or participation in significant activities.

5. Feeling of detachment or estrangement from others.

6. Restricted range of affect (e.g., unable to have loving feelings).

7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)." (DSM-4,1994)

The inability to recall important aspects of the trauma explains why children who have experienced trauma may change their stories or forget them altogether. For example, Juanita comes from a country that has been at war for many years. She and her family moved to the U.S. last year. She avoids talking about any of her experiences in her native country, even when speaking to a teacher who speaks her first language. It seems as if she has completely forgotten living anywhere else. When prompted by the teacher about an important event such as a demonstration Juanita attended in her country that ended in bloodshed, she doesn't remember anything about it. Juanita appears very shy and shows little interest in exciting activities such as birthday celebrations. She often seems to be hanging around the "edges" of the classroom and has few friends. In addition, Juanita doesn't show much affection, attachment, or loving feelings toward her mother or brother. If she plays in the dramatic play area, she never takes a role where she expects to have a future. She makes statements such as "I won't ever be a mother or get married. I'll play the baby." The most important indicator is that the child *did not* display the symptoms before the trauma occurred.

Again, note any observations of these symptoms; this will help the professional diagnostician when you make a referral. (The section on *Working with the Family and Professionals*, which appears later in this resource file, details the referral process.)

Symptoms of Increased Arousal

"Persistent symptoms of increased arousal (not present before the trauma) are present as indicated by at least two of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilance.
5. Exaggerated startle response." (DSM-4, 1994)

For example, when Mim, Terry's teacher, spoke to Terry's mother, her mother reported that Terry had a hard time falling asleep and often ended up in her bed by morning. Mim had already noted Terry's difficulty in concentrating in the classroom. One day when Mim touched Terry's shoulder from behind Terry jumped as if she had been hit. This would be an example of an exaggerated startle response.

Clinically Significant Distress

"Duration of the disturbance (symptoms listed above) is more than one month. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning." (DSM-4, 1994)

For example, Jackson has often witnessed domestic violence. Last week his father and mother were fighting. Jackson's mother reports that he slept through the entire incident. At one point, Jackson's father stormed out of their apartment. As he was leaving, he smashed in the window over Jackson's bed. Jackson's mother reports that she thinks Jackson was unaware of much of this

trauma. He was not hurt by the broken glass. He woke up when the glass fell all over his bed, but his mother was able to calm him and rock him back to sleep after things quieted down.

The classroom teacher reports that Jackson has difficulty concentrating on tasks, often wandering around the room aimlessly. When the teacher dropped a cup of coffee and it clattered on the floor, Jackson visibly jumped and appeared very frightened. He seems very irritable and occasionally sweeps all the toys off the table for no apparent reason. Before the traumatic event, Jackson rarely showed anger in this way and had a sunny, warm personality.

The symptoms and examples discussed above demonstrate what would be termed as *clinically significant distress*. A teacher's input is helpful in documenting any distress or inability to function successfully in the classroom, or when a child shows any of the symptoms. This would be a reason for referral.

WORKING WITH CHILDREN DIAGNOSED WITH PTSD

ADDITIONAL SYMPTOMS OF PTSD

The DSM-4 lists many specific symptoms that must be present for a diagnosis of PTSD. In addition, there are several additional symptoms that may be present and that a teacher may see exhibited in the classroom.

Hyper And Hypovigilance

Mercedes was a child who seemed irritable and uncommunicative; a loner who occasionally erupted in aggressive behavior. A child with these symptoms could be diagnosed with a number of disorders or with no disorder, if she is just experiencing family change or dealing with other issues. The teaching methods and the classroom environment should support Mercedes no matter what the cause of her behaviors. Keep in mind that many classrooms have children with PTSD, whether or not it has been diagnosed.

Children with PTSD are very sensitive to the environment. Hypervigilance or hypovigilance are symptoms of PTSD. This means that Mercedes was either extremely aware of everything going on around her or totally unaware of anything going on. However, Mercedes would probably be able to tell Cheryl, her teacher, in great detail everything going on in the hall, as well as an incident across the classroom Cheryl thought she had no way of knowing about. Mercedes, and other children with PTSD, saw that this knowledge was lifesaving. While Mercedes was aware of all of these details, she also seemed engrossed in building with blocks. She was unresponsive when Cheryl spoke to her. It seemed like a complicated picture. It was complicated because Mercedes's behavior may have seemed oppositional or disrespectful. However, it was the way Mercedes had learned to stay safe. Knowing everything that was happening around her as well as keeping totally immersed and distracted by an activity may be the way she kept as safe as possible at home or wherever she felt she was at risk.

Sensitivity to Sound

Loud noises often frighten young children. Children exposed to trauma and with PTSD will react to loud noises in more extreme ways than their peers. It is important that children with PTSD be informed, if possible, when a loud noise will occur, such as during a fire drill or construction work. They may need to see the origin of the noise to believe that they are indeed safe. In addition, the overall noise level in the classroom has significant impact on these children. The room should be as calm as possible. Adult voices should be calm; a firm, loud voice can re-traumatize a child with PTSD. A firm, gentle voice giving simple, clear expectations of behavior is more appropriate.

When the classroom gets loud even in appropriate ways, a child with PTSD may run for cover. The teacher's sensitivity to this reaction is important. Giving a child advance notice of any change helps him order his world and gives him some control. For example, Michael, a new teacher assistant, often uses a loud voice in the classroom to try to help children manage their behavior. Shirley, the teacher, explains to Joe, a child with PTSD, that Michael is learning to use a quieter voice but he sometimes forgets. This way, Shirley helps Joe understand that the loud voice doesn't necessarily mean danger. It also reassures Joe that Shirley is aware of his need for a calm and quiet environment.

Sensitivity to Touch

Touch can be a major issue for children with PTSD, especially if they have been physically or sexually abused. It is critical that teachers be sensitive to the children's vulnerability. Children with PTSD often lack appropriate boundaries or shy away from touch. The teacher can help by first telling the child that she will touch him before doing so. She should ask permission and respect the

child's right to say no. Under no circumstances should a teacher touch a child without warning when the child has said no. For example, if Jwahara refuses to move where Paula, the teacher, has asked her to go, Paula might take these steps:

- First, she would verbally ask Jwahara to move. "Please go to the circle area now."
- If she says no or does not respond, then Paula would say, "Do you need help to get to the circle area?"
- If Jwahara still does not respond then Paula might say, "It is time to go to the circle area. Can I help you get there now by taking your hand?"
- Paula would pause for a few seconds and then touch Jwahara.

In this way Paula would give plenty of time for Jwahara to understand the request and allow her to choose how she gets to the circle area. Children sensitive to touch will rarely wait for the final request.

In addition, children with PTSD may not show physical affection, or they can be inappropriately affectionate. Some children have few boundaries around touch and will touch teachers and other adults and children in inappropriate ways. Teachers help children by providing boundaries. This may be as simple as saying, "I don't like it when you touch me that way, Susie. You may touch me this way or sit in my lap." Remember that some children's experience with touch (especially those who have been sexually abused) is inappropriate and they truly do not have boundaries or know the appropriate ways of touching.

HOW TO MAKE A SAFE CLASSROOM ENVIRONMENT

Every classroom environment should feel safe to all children and adults who enter it. Children with PTSD do not feel safe. However, by creating a safe environment and teaching the children exactly why it is safe, children with PTSD will come to some understanding of safety, even when they may not feel safe themselves.

What is a safe classroom environment? For adults who have grown up feeling safe, it may be difficult to see how subtleties and attitudes make a safe environment. The first thing a child with PTSD looks for are any signs that remind him of the trauma he suffered. Since any classroom may include children who have been exposed to a variety of traumatic events, it is important to recognize some of these signs. The child's family and/or therapist can be very helpful in assisting you. Some examples might include a child drawing pictures of scary events or angry adults; observing adults locking doors when securing cleaning supplies; or even just closing the door. Again, these signs are very individualized and only the therapist or family can help you with a particular child.

SAFETY

In her book *Trauma and Recovery*, Judith Herman discusses the meaning of safety. Safety looks the same for traumatized children as it does for adult survivors. According to Herman: "...they feel unsafe in their bodies. Their emotions and their thinking feel out of control. They also feel unsafe in relation to other people" (Herman, 1992).

Establishing safety "begins by focusing on control of the body and gradually moves outward toward control of the environment. The issues include attention to basic health needs, regulation of bodily functions such as sleep, eating, and exercise management of post-traumatic symptoms, and control of self-destructive behaviors. Environmental issues include the establishment of a safe living situation..." (Herman, 1992). The author adds that "establishing a safe environment requires not only the mobilization of caring people but also the development of a plan for future protection" (Herman, 1992).

The classroom teacher has much to gain from considering this definition of safety. Children with PTSD need help to feel safe in their bodies. Developmentally, preschool children have not yet separated their minds from their bodies or their bodies from the rest of the world. They are in the middle of this process and trauma arrests this development. Consequently, children with PTSD generally feel unsafe. Much of the work to regain a sense of safety will happen with a skilled therapist, yet teachers also can play a role in the children's development.

Learning Safety

Think about how an infant learns safety. Takisha, 1 month old, begins to learn safety when her needs are met in a timely way. When she cries, someone will come and help her. She learns that adults will hold her in a comfortable way. A child who has been sexually abused may need to be held in different ways. Takisha learns that when she awakes, someone will come and pick her up, especially if she cries or calls. In short, infants learn safety by having their basic needs met in a caring way. Children who have PTSD need to re-learn safety

because their *sense of safety* has been interrupted by the traumatic event(s). They need reassurance that if they require something, a caring adult will help.

In the classroom, it can be as basic as knowing that if Joshua cries, the classroom staff will comfort him in the way he likes to be comforted. For example, sitting on an adult's lap may remind him of his abuse. He needs to know that the staff will protect him from danger. Joshua will learn this over time. It helps when staff verbalize that the classroom is safe but he will need the direct experience of that safety. If loud noises particularly scare Juanita, staff can show her safety when they warn her about an impending loud noise and a staff member stays by her side when it happens. Staff may also help Juanita by asking what will help her feel safe at that stressful moment.

Feeling Secure in the Classroom

Feeling safe is a major issue for children with PTSD. Safety means having a family, home, enough food, and exercise. Children with PTSD have often lost some aspect of their safety, depending on the type of trauma endured. A teacher cannot promise a safe world, yet she can re-enforce the safety of the classroom environment and the staff at the center. This is done by both reassuring everyone that the teacher's job is to keep everyone safe and then explaining exactly how it will be done. Staff must consistently adhere to this promise. If Van Hai, a teacher, says that safety in his classroom means he will help children when they have a problem, then he must be sure to do that. If Van Hai says that yelling, hitting, and kicking are not safe behaviors inside, then he must help children who use these behaviors find other ways to express their anger. It means that Van Hai must validate everyone's feelings. All feelings are acceptable, and he can help with appropriate ways to express them. This is especially important to

children with PTSD because they often cannot express any emotions, or they erupt inappropriately. They need to know that their feelings are always OK and the staff will help them express them in safe ways.

Activities that Promote Safety

As a teacher, Julie might begin by examining just how she feels safe in her body and then thinking about how that might translate to a young child. Doing exercises that focus attention on specific body parts is one way Julie might help her class connect with their bodies. Children can successfully do this type of exercise for a short time. The teacher should be sure to choose a body part that is most benign, for example, fingers, hands, or feet. Another exercise Julie might choose to help her class connect with their bodies would be by focusing on breathing. This can be effective for some children. However, for others it may trigger a memory of abuse (e.g., if the child was instructed to hold her breath or was smothered by a pillow).

Always begin these focusing exercises by encouraging children to do only what they want or feel safe doing. Consult with the disabilities coordinator and the individual child's therapist before doing this kind of work. However, all children benefit by learning techniques for focusing. When children begin to feel empowered in the safe classroom environment, they begin to experience some control of their bodies as well. Teachers' respect for each child's body and choices is critical for all children but especially for children with PTSD.

Focusing Exercise

Begin by having the children either sitting cross-legged or lying on the floor. The teacher should also be sitting on the floor. Using a soft, calm voice ask the children to do the following:

We're going to play a game to help you learn to calm yourself.

- **Put your hands on your knees or by your sides.**
- **If you feel safe, close your eyes.**
- **Begin to listen to your breathing.**
- **Take in a breath and let it out.**
- **Feel your breath go all the way down to your stomach and then feel it come back out.**
- **Take another deep breath and feel it go to your stomach and feel it come back out.**
- **Feel your body becoming calmer and more relaxed.**
- **When you feel ready open your eyes and become aware of the sounds in the room.**

This exercise is very simple and short. It is a good way to begin to help children learn to calm themselves and have some control over their own bodies. It will probably take many experiences with this exercise for children to become comfortable with it. When the children are comfortable with this short exercise, it would be time to introduce more complicated meditations and focusing exercises. See the Related Readings at the end of this file for some appropriate books to use with children.

Living in Chaotic Communities

This reassurance is more difficult when the classroom is located in a community that is chaotic. Children with PTSD will have a hard time believing the staff will keep them safe if gunfire occurs around the center. The staff will probably also have a hard time feeling safe under these conditions. But they can validate the children's feelings that gunfire is scary and restate that their intention is to keep the children safe. Then the staff can add the steps they take to keep everyone

safe if someone is shooting around the classroom. For example, someone calls the police; everyone goes to a safe place; the staff stays with the children. Helping children feel safe is also very difficult if they go home to unsafe environments. Sometimes children will be picked up by someone who is abusing them. For these children the staff can only promise that the classroom is safe and nothing hurtful will happen to them there. Staff can't promise that unsafe people won't come in because some children live with adults who still abuse them.

RESPONDING TO DEVELOPMENTAL DELAYS

Children with PTSD need to learn self-care and self-soothing, which may not have developed at the appropriate time. For example, Ian may find thumb-sucking very soothing and a way to calm himself. This is appropriate for most preschool children and especially for those with PTSD. Toilet-training or bedwetting may be an issue for children with PTSD. Teachers should respond to this need as if the child was developmentally delayed as she would for any other diagnosis. Toileting is one of the few ways preschool children can control their bodies. Children who have been sexually abused may particularly have difficulty around toileting issues. In general supporting children exactly where they are and in the ways they request is the best guideline for developing safety for children with PTSD. However, children who have been abused over long periods of time may expect to always be abused and may not feel safe even when they are being treated with respect in a safe environment.

ROLE OF THE CLASSROOM STAFF WITH THE CHILD AND FAMILY

The most crucial piece of the picture when working with children with PTSD is the role of the classroom staff. The classroom staff of a child with PTSD must have genuine respect for that child as he or she is. There can be no value judgments, or *poor baby* responses, or even attitudes. It is tragic that children endure trauma and develop PTSD. It shouldn't happen. But it does. The children need unqualified understanding and acceptance at all times. Adults can never assume they know what that child is going through, even if they also have PTSD. Each experience is as individual as the child. Understanding of these individual differences, while always important, is especially important when working with a child with PTSD.

The adult's behavior in the classroom is critically important in providing the safe environment discussed above. It is important to understand that:

- all emotions are appropriate and worth validating.
- children with PTSD can learn appropriate behaviors and heal.
- no child ever asks to be abused or traumatized.
- every child in the class truly wants to behave appropriately - some children just don't know how or don't feel safe.

The adult must be able to stay calm with children who are out-of-control to show them that they are safe, even when they are out- of-control. Sometimes children with PTSD will push some buttons and trigger inappropriate responses from the staff. It is helpful if each staff member knows what will act as a trigger so that

the team can identify the most appropriate adult to intervene. The staff must be able to accept different behaviors from different children. Sometimes a child will be out-of-control today and warm and sunny tomorrow. Classroom staff must be committed to following two rules: (1) No one can be hurt by anyone, and (2) No one can destroy any materials. They should be the only rules. Keeping things simple will make everyone's job easier and help everyone feel safer.

All children should be respected. The process for healing from PTSD varies from child to child. It changes, sometimes with lightening speed. Staff must be willing to ask for help whenever they have a question or new observation. They should not assume that things can be handled easily. Even the most experienced teacher will need help from professionals in working with children with PTSD. They should feel comfortable asking for help before burn out occurs from dealing with the extremes that children may present. They can take credit for providing a safe and consistent environment that allows for individual differences. Children are receiving something very valuable in this environment. Children with PTSD will heal more easily when provided with a supportive environment and caring adults.

BEHAVIORAL ISSUES

The classroom staff has made a promise of a safe classroom. What comes next? How does the environment feel? How do staff make rules and how are they kept? Who has the control? Children with PTSD often feel out of control. Staff can help by giving them as much choice and control in the classroom as they can handle. Staff set the stage for a safe environment and then give much of the

control and choice to the children. Does this mean that chaos reigns? Absolutely not! It means that the staff have a few rules that they consistently reinforce. It means that staff individualizes as much as possible. It means all children are accepted as they are so that they can feel safe in the classroom. Children are offered choices so that there is always an opportunity for success even if a child is having a difficult day. A difficult day for a child with PTSD may mean complete withdrawal or unusually aggressive behavior. Classroom staff should have a plan for either situation for every day. For example, some days Elizabeth spends hours playing in the dramatic play area without interacting very much. Other days she seems like a different child, running all over the classroom, destroying the work of others and crying easily. Curriculum plans should be flexible to adjust to either type of day.

INDIVIDUALIZING BEHAVIOR MANAGEMENT

Children with PTSD will often display behaviors that concern teachers and interrupt classroom life. As described above, these children can either be extremely withdrawn or very aggressive, often switching without warning or for reasons not understood by the teaching staff. It is critical that teachers understand that children with PTSD are not always in control of their bodies and that a huge variety of situations may *set them off*. So what can a teacher do? Again, the emphasis on a safe classroom environment is key to helping children with PTSD manage their behavior. Even then they may just be unable to control themselves. They often don't understand why they continue to resist all attempts to help them ... a difficult situation at best. Since the children don't understand why they are unable to control their behavior at times, asking them

to think about what they did and why it was wrong is a confusing and sometimes impossible request.

Time out does not work well for children with PTSD. It reinforces their feelings of lack of control, which can trigger memories of the trauma. This doesn't mean that the children should not learn to modify their behavior. In fact, it is very important that children with PTSD learn acceptable ways to express their emotions. Part of making a safe classroom environment is being very clear about the classroom expectations and how they can be met. There are only two rules essential to every classroom:

1. No one can be hurt by anyone.
2. No one can destroy any materials.

Even children with few boundaries and difficulty controlling themselves can understand these simple rules which, in fact, help them feel safe. Children with PTSD feel more secure when they know that the staff will help them and the other children follow the rules.

Consider this example: Angie has repeatedly ignored her teacher James' request to help clean up the room before lunch. (This could be hypovigilance.) James is at the end of his patience. He knows she heard him but she just doesn't respond. James raises his voice and says, "Angie, it is clean up time now. If you can't help us clean up you will have to sit in the time out chair." Again, no response. James touches Angie's shoulder in an effort to get her attention. She screams, "NO! NO! NO!," and throws herself on the floor, crying. Obviously, something has set Angie off. It could have been James' voice tone, the volume of his voice,

or the fact that he touched her. Angie may be yelling NO! because she is remembering the trauma or because she is afraid that James will put her in the time out chair. In any event, Angie has lost control of her body and is probably terrified. James is confused. He has used this technique with many "difficult" children and it has almost always worked. James didn't mean to scare her or seem threatening. What else could he have done?

Another look: Angie has repeatedly ignored James' request to clean up the room before lunch. He knows she has PTSD and sometimes seems physically present but appears unconnected to any classroom activities. James also knows that a loud and firm voice scares her. Angie is also hypersensitive to touch of any kind. James sits down beside Angie on the floor where she has full view of him. He puts his head at the same level as her head and just spends a minute looking at her. James says Angie's name and sees if she looks at him. When Angie looks at James, he could repeat his request to help with cleaning up. He might say, "Angie, I know you have a hard time cleaning up. I will help you. In what way can I help you?" When she does respond, James shows her a small, manageable task in cleaning up and begins to put the toys away. He asks her to help him. He acknowledges that Angie is having a hard time listening today. He is very gentle and slow in his movements. He could say, "It seems very loud and busy in the classroom at clean-up time. That might seem hard for you. Even though it is loud and busy, this is a safe place. I will help you get through this hard time. We can stay over here cleaning up until you feel safe enough to join the group. I'm glad you are able to hear me now."

It is vitally important that James remain calm and not get frustrated. Angie is not ignoring James because she is disobedient. Angie is unable to deal with the

situation before her for any number of reasons. It is not a personal issue. James' role is to find a way to help Angie as much as possible when she tunes out and help her re-connect to the classroom activities. James' gentleness and nonjudgmental attitude will show Angie that she is safe no matter how she behaves. If James finds that Angie is tuned out often, he would be sure to note these observations and share them with the disabilities coordinator and others at the team meeting. At this time he could also ask for recommendations to help him. The more information James has about the ways Angie may react to different situations the better he will be able to plan. Two minutes after this whole interchange Angie may be fully involved in classroom activities, as if nothing unusual happened. This is normal for children with PTSD. Their feeling of safety can change minute by minute.

SETTING LIMITS IN THE CLASSROOM

Setting limits in the classroom involves discussing the rules, what they mean, and the consequences when a rule is broken. Again, keep the rules simple and have as few as possible. Involve the children in setting the consequences for not following the rules. Also point out that the consequences might be different for different children. Some children benefit from a few minutes alone to calm down when they get out of control. As mentioned above, few children with PTSD benefit from time alone. It is too scary for them. They need reassurance and guidance in how to stay safe, which includes following the rules. The classroom should include a variety of quiet areas for children to use for calming. For some children, building with blocks is very calming, but doing nothing is terrifying or confusing. It is important that classroom staff know the individual differences in the classroom so that they have plenty of options. Asking the

children what helps them calm down (at a time when they are already calm) is a great way for staff to plan the strategies and make sure all children have safe places to regain their composure. Know in advance whether the child needs or wants adult companionship when she has a need to calm down. Children with PTSD need different options depending on the type of trauma they endured and their personality. Always respect their requests. For example, Carol, a staff member, is worried that Petra should have adult companionship while calming down. Petra has said no to this companionship; therefore Carol must be sure to give Petra some space. Carol would tell Petra that she is worried that she might hurt herself or someone else so she is planning to stay close by and help Petra if she needs it.

MAKING A REFERRAL

Picture observing a child who has been sexually abused. Joshua was three years old. Prior to the abuse, he appeared to be developmentally appropriate in all areas. Joshua was appropriately verbal; he showed affection and attachment to his family as well as anger when something happened such as a toy being grabbed away. Both his teachers and family considered him *normal*. Joshua spent two months in the summer with his grandparents. When he returned Joshua was more silent than verbal. He had little to report about his visit. In addition, Joshua had frequent nightmares featuring *a huge monster*.

He varied from being overly submissive to showing intense rage over little things. Joshua rarely participated in circle or other group activities and never engaged in cooperative play. One day when a man with a mustache entered the classroom, Joshua screamed and ran to hide in a corner. Another day when his

teacher approached Joshua from behind and gently touched him, he visibly jumped. Joshua was unable to lie still at rest time; his parents reported that it took him a long time to fall asleep, only to be awakened by nightmares. One of his favorite games was playing with the barn, putting the man and boy in the barn, shutting the door and barricading it with blocks. These observations would warrant a referral to the disabilities coordinator, who could involve a professional qualified to diagnose PTSD.

In the above example, a number of "red flags" went up for a teacher or parent to observe. The most significant observation was the radical change in the child's behavior. This could be attributed to a number of things. However, because Joshua was sexually abused, it probably would lead to a diagnosis of PTSD. Additional symptoms included Joshua's reluctance to participate with others, his lack of emotion and overreactions.

Irritability is another symptom of PTSD. The most significant or perhaps alarming symptom was Joshua's reaction to the man with the mustache, which triggered a fear of a specific stressor (i.e., perhaps his abuser had a mustache). His repetitive play was another symptom of PTSD as were his nightmares, especially since his parents reported he did not have nightmares before the abuse.

A teacher cannot make the diagnosis of PTSD but can involve the disabilities coordinator, who would then refer Joshua's family to a child psychiatrist or other professional. The staff team would want to know what, if anything, the family had done in terms of treatment for the abuse since they became aware of it.

It is important to remember that PTSD often seems invisible in children after some time has passed. This is why children often change their story when asked about the trauma. It does not mean the trauma did not occur or that they are not suffering from PTSD; rather, they have repressed the memories. Again, it is not the teacher's responsibility to hear the story or drill the child to get information. An evaluation should only be done by a professional experienced in working with children with PTSD or other trauma-related disorders.

WORKING WITH THE FAMILY AND PROFESSIONALS

Children develop PTSD for many reasons. Many children go undiagnosed or misdiagnosed for many years, even until adulthood. It is essential that teachers working with children diagnosed with PTSD work as a team with the coordinators, the children's families, and any professionals treating the children. Many families may seem to deny the extent that the trauma has affected their child. This is not because they don't want to help the child, but because they wish the trauma hadn't happened. Families often feel somehow responsible for the trauma. They also feel they should have prevented it. They believe that if they don't mention the trauma they are helping their child recover. This is not true. The family needs to validate the child's experience and make it part of the family history they are creating together. In this way, it validates events that just don't make sense to the child and reassures him that he is not at fault for the trauma. For example: Angie's family makes a comment to the teacher, James, that they don't think the trauma has affected Angie's behavior. James might then turn to his disabilities coordinator for help in having the parents understand the situation and agree to mental health referral.

If a family member is the perpetrator in an abuse situation, it becomes much more difficult to include the family in this way. Again, careful documentation will assist the disabilities coordinator, family service worker, and director in helping the child and family. It is not the teacher's responsibility to make a diagnosis but there is a responsibility to document any behaviors that look as if they may be symptoms of PTSD. Because the classroom staff see the child in a neutral, non-traumatic environment over time, they are an excellent resource to the professional team who will evaluate and treat the child.

When children with PTSD are being discussed, the team should include the classroom staff and any other adults that come into contact with the child such as the disabilities coordinator, the family service worker, the professional treating the child, and even the bus driver. The team will be able to work on strategies that particularly meet the child's needs and may help identify undiagnosed children in the classroom. It is critical to refer children to a professional who is experienced in working with children with PTSD. This may be very difficult since it is a relatively new diagnosis. As more research about preschool children with PTSD is done, professionals will emerge with the expertise in treating children with this disorder. A referral to the pediatrician may not be appropriate at this time. "General doctors, however, have not become well enough informed about the signs, symptoms, and findings of childhood psychic trauma to be counted upon across the board for reasoned opinions. Advising the reader to consult with his physician about a potentially traumatized child will probably be a good piece of advice ten years from now, but it is not timely now" (Terr, 1990).

While often team meetings with professionals don't include everyone listed above, everyone working with the child should hear the same message at the same time. Children with PTSD need as much consistency in the way they are treated as possible. This is one way to ensure that consistency. Remember, **document, document, document!** All staff should ask for help when they aren't sure how to handle a situation. Children with PTSD are emotionally fragile and each situation is different. Asking for help can keep staff sane and ensure that the program provides a safe environment. Remember how nebulous safety is for children with PTSD.

CONCLUSION

Working with children with Post-Traumatic Stress Disorder can be extremely frustrating and extremely rewarding at the same time. The classroom staff can observe many behaviors and document many experiences that will help a professional diagnose and treat a child with PTSD. The staff can provide a wonderful environment for healing both by their own attitudes and how they organize the classroom. Each adult is a very important member of the team helping a child with PTSD. In addition, when the staff helps a child with PTSD, they are also providing the same respect and considerations all children deserve.

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